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CUMBERLAND NURSING AND REHABILITATION CENTER	200 NORFLEET DRIVE SOMERSET, KY 42501

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY23657, KY23665) was initiated on 08/10/15 and concluded on 08/11/15. Complaint #KY23665 was unsubstantiated with no deficiencies. KY23657 was substantiated and deficient practice was identified with the highest scope and severity at 'G' level.	F 000		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility policy, and review of the facility's	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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investigation it was determined the facility failed to ensure the plan of care was revised after a change in behavior was identified for one (1) of three (3) sampled residents (Resident #1). The resident was witnessed to be standing without assistance by staff. However, the facility failed to ensure this change in the resident's behavior was added to the care plan. The resident demonstrated this same behavior hours later, which resulted in a fall with multiple facial fractures and fracture of the humerus (upper arm).

The findings include:

Review of the facility's policy titled "Care Plan Policy Statement," date unknown, revealed any licensed nurse and/or interdisciplinary team member could update the care plan to reflect changes and that care plans were revised as information about the resident and the resident's condition changed.

Record review revealed the facility admitted Resident #1 on 07/31/15, with diagnoses that included Confusion and Dementia. Review of the nursing "Admission Assessment" dated 07/31/15, revealed the resident was assessed to be alert, confused, and to be experiencing poor short and long-term memory problems. Further review of the Nursing Admission Assessment revealed the facility assessed the resident to have mild to moderate cognitive impairment and to require assistance with mobility.

Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 07/31/15, revealed the resident was referred to OT due to "new onset of decrease in strength,

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decrease in functional mobility, decrease in transfers, reduced balance, reduced ADL (Activities of Daily Living) participation, increased need for assistance from others and decreased coordination placing the patient at risk for falls."

Review of the resident's Plan of Care, dated 07/31/15 and revised on 08/03/15, revealed the resident was at risk for falls related to confusion and dementia and required the use of a chair alarm when using a wheelchair.

Review of statements taken by the facility as part of an incident investigation, date unknown, revealed Licensed Practical Nurse (LPN) #1 stated that on 08/03/15 during second shift, Resident #1 was found to be standing without assistance in front of his/her wheelchair and the chair alarm was sounding. The LPN also stated the resident was found standing without assistance again later during the shift.

Review of the facility's "Resident Incident Follow-up," dated 08/04/15, revealed on 08/03/15 at 11:55 PM, Resident #1's roommate reported to staff that Resident #1 was sitting next to his/her bed on the floor. Further review revealed LPN #3 and Certified Nurse Assistant (CNA) #3 entered the resident's room and assessed the resident, finding no injuries. The resident was assisted to the bedside commode and then back to bed.

Review of CNA #3's statement taken by the facility on 08/04/15, revealed after assisting the resident back to bed the resident "kept trying to get up." The CNA stated he assisted the resident to the wheelchair and placed the resident at the nurses' station where LPN #3 was receiving medications with a pharmacy medication delivery

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person. CNA #3 stated, "I went up front to get a wheelchair alarm, while getting the alarm the resident fell hitting the station."

Review of the History and Physical from the hospital, dated 08/04/15, revealed Resident #1 was admitted to the hospital after the fall from his/her wheelchair which resulted in left facial fractures, as well as a left humerus (bone in the upper arm) fracture.

Interview with LPN #1 on 08/10/15 at 4:45 PM revealed on two (2) occasions during the evening shift on 08/03/15, she was alerted by Resident #1's chair alarm and found the resident standing in front of his/her wheelchair without assistance. The LPN reported after finding the resident standing without assistance the second time, she placed the resident in the hallway for closer observation. Further interview revealed this was a new behavior for the resident; however, LPN #1 reported she did not update the resident's plan of care to reflect the change in behavior.

Interview with LPN #3 on 08/10/15 at 5:55 PM revealed she was not aware the resident had been standing without assistance during the previous shift or required the use of a chair alarm. However, review of the resident's care plan revealed this information was on the care plan. The LPN stated she was responsible for reviewing the Plan of Care for residents who were newly admitted to the facility; however, she had only briefly reviewed the Plan of Care for Resident #1 after the resident's fall on 08/04/15. Further interview with LPN #3 on 08/11/15 at 4:20 PM, revealed the resident's recent change in behavior related to standing without assistance was not on the care plan. The LPN stated

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F 280	Continued From page 4 changes with residents should be on the care plan and passed on in report from shift to shift. Interview with the Unit Manager (UM) on 08/11/15 at 3:45 PM revealed a resident's Plan of Care directed nursing care; however, she was unsure how often nursing staff should be reviewing the Plan of Care. Further interview revealed any updates or changes with resident care should be noted on the care plan. Interview with the Director of Nursing (DON) on 08/11/15 at 4:50 PM revealed changes in resident behavior should be placed on the care plan; however, nursing staff was not responsible to routinely review the care plan. The DON stated that changes in resident behavior were to be reflected on the care plan. Further interview revealed the facility did not have a system to ensure information was passed from one shift to the next shift. Interview with the Administrator on 08/11/15 at 5:45 PM, revealed the change in the resident's behavior should have been passed on in report and placed on the care plan. The Administrator stated nursing staff should review the care plans daily.	F 280		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		

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by:
Based on interview, record review, policy review, and review of facility investigation it was determined the facility failed to ensure a safety alarm was used in accordance with one (1) of three (3) sampled residents' written plan of care (Resident #1). On 08/04/15, Resident #1 experienced a fall, related to standing without assistance from his/her wheelchair, resulting in multiple facial fractures and a humerus (upper arm) fracture. Interviews with facility staff revealed the resident did not have a safety alarm in use during the time of the fall as indicated in the resident's plan of care.

The findings include:

Review of the facility's policy titled "Care Plan Policy Statement," no date, revealed the care plan was designed to incorporate identified problem areas and aid in preventing or reducing declines in the resident's functional status and/or functional levels.

Record review revealed the facility admitted Resident #1 on 07/31/15, with diagnoses that included Confusion and Dementia. Review of the Nursing Admission Assessment dated 07/31/15, revealed the facility assessed the resident to be alert, confused, and to be experiencing poor short and long-term memory problems. Further review of the Admission Assessment revealed the facility assessed the resident to have mild to moderate cognitive impairment. The facility assessed the resident as requiring assistance with mobility.

Interview with Licensed Practical Nurse (LPN) #2 on 08/10/15 at 5:20 PM revealed she participated in Resident #1's admission assessment on

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07/31/15. Further interview revealed Resident #1's family had indicated the resident had fallen at home prior to admission to the facility. The LPN stated a chair alarm was implemented upon admission, as a fall prevention intervention.

Interview with Certified Nurse Assistant (CNA) #1 on 08/10/15 at 5:37 PM revealed she had also taken part in Resident #1's admission process and confirmed a chair alarm was implemented upon admission to prevent falls.

Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 07/31/15, revealed the resident was referred to OT due to "New onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced balance, reduced ADL (Activities of Daily Living) participation, increased need for assistance from others, and decreased coordination placing the patient at risk for falls."

Review of the resident's Plan of Care dated 07/31/15, revealed the resident was at risk for falls related to confusion and dementia and required the use of a chair alarm when using a wheelchair.

Review of the facility's investigation revealed a written statement made by CNA #3 on 08/04/15. The statement revealed CNA #3 discovered the resident on the floor of the resident's room on 08/03/15 at approximately 11:50 PM. LPN #3 and CNA #3 assessed the resident finding no injuries, assisted the resident to the bedside commode, and then assisted the resident back to bed. CNA #3 reported that the resident "kept trying to get up" resulting in the CNA assisting the resident to his/her wheelchair and positioning the resident by

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the nurses' station. Further review revealed the CNA then left the resident to obtain a wheelchair alarm during which time the resident fell from the wheelchair hitting the nurses' station. The resident was sent to the hospital for evaluation.

Review of the History and Physical from the hospital dated 08/04/15, revealed the resident was admitted to the hospital on 08/04/15 after sustaining a fall from his/her wheelchair resulting in a left orbital floor (facial bone) fracture, left sinus fractures, left maxilla (upper jaw bone) fracture, and a left humerus (bone in the upper arm) fracture.

Interview with LPN #3 on 08/10/15 at 5:55 PM revealed she was responsible for Resident #1's care on the morning of 08/04/15 when Resident #1 experienced a fall at approximately 12:20 AM. Further interview revealed at approximately 11:50 PM on 08/03/15, Resident #1's roommate alerted staff that Resident #1 was sitting on the floor beside his/her bed. The LPN stated she and CNA #3 entered the resident's room, assessed the resident, and found no injuries. They assisted the resident to the bedside commode and then back to bed. The LPN stated she was then called from the room due to the medication delivery person arriving to check in medications. Further interview revealed the LPN was told by CNA #3 the resident would not stay in bed. She stated CNA #3 placed the resident in his/her wheelchair and brought the resident to the nurses' station in order for staff to monitor the resident. LPN #3 stated an alarm was not on the resident's chair. She instructed the CNA to obtain a chair alarm for the resident at that time. Further interview revealed the LPN began checking in medications with the medication delivery person by the nurses'

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station and witnessed the resident stand up from his/her wheelchair without assistance and immediately fall forward to the floor at approximately 12:20 AM on 08/04/15. LPN #3 further stated she had not reviewed Resident #1's care plan and was unaware the resident was care planned for an alarm. LPN #3 stated she instructed the CNA to place an alarm on the resident's chair, because nursing staff utilized their judgment when a chair alarm was necessary and they did not have to get a Physician's Order.

Interview with the medication delivery person on 08/11/15 at 1:19 PM, revealed he was present at the facility on 08/04/15 at 12:20 AM. The medication delivery person stated no alarm was sounding prior to the fall sustained by the resident.

Interview with CNA #3 on 08/11/15 at 3:15 PM, revealed he assisted Resident #1 to his/her wheelchair and to the nurses' station on 08/04/15. CNA #3 stated a chair alarm was not in use prior to the resident's fall. Further interview with the CNA revealed he was not aware the resident required a chair alarm when in a wheelchair. The CNA stated the facility "Accunurse" (headset system) provided him with the resident's fall prevention interventions; however, he was unsure what interventions were in place for the resident prior to the fall on 08/04/15. The CNA stated he was not informed during the shift-to-shift report, that the resident required a chair alarm, per the Plan of Care.

Interview with the Unit Manager (UM) on 08/11/15 at 3:45 PM, revealed she was unsure what Resident #1's fall prevention interventions were and she was not aware the resident did not have

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F 282	Continued From page 9 a chair alarm in place at the time of the fall on 08/04/15. Further interview revealed nursing staff was not required to routinely check resident care plans, even though care should be directed from the care plans. Interview with the Director of Nursing (DON) on 08/11/15 at 4:50 PM revealed she was aware that Resident #1 had been assessed upon admission to be at risk for falls and a chair alarm had been implemented as a preventive measure. The DON stated an alarm placed upon admission should be included on the care plan and the care plan should be followed. Further interview revealed care plans were always available to nursing staff; however, they were not responsible to review the care plans routinely. Interview with the Administrator on 08/11/15 at 5:45 PM, revealed nursing staff was responsible to review and follow resident care plans daily. Further interview revealed, according to the Plan of Care, Resident #1 should have had a chair alarm in place prior to the fall that occurred on 08/04/15.	F 282		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

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by:
Based on interview, record review, facility policy review, and review of the facility's investigation it was determined the facility failed to ensure assistance devices were provided to prevent accidents for one (1) of three (3) sampled residents (Resident #1). The facility assessed Resident #1 to be at risk for falls and a care plan intervention was developed for a chair alarm while the resident was up in a wheelchair.

On 08/03/15, during the evening shift, the resident was witnessed to be standing without assistance, which was a change in behavior for the resident. On 08/04/15, Resident #1 was assisted to a wheelchair and taken to the nurses' station without a chair alarm in place, which was required per plan of care. Resident #1 got up from the chair unassisted and fell, resulting in multiple facial fractures and a fracture to the humerus (bone in the upper arm).

The findings include:

Review of the facility's policy titled "Incidents and Accidents," undated, revealed all incidents and accidents were reported using written and verbal format.

Review of the "Care Plan Policy Statement," undated, revealed a comprehensive care plan was developed for each resident and any licensed nurse and/or interdisciplinary team member could update the care plan to reflect changes.

Record review revealed the facility admitted Resident #1 on 07/31/15, with diagnoses that included Confusion and Dementia. Review of the

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Nursing Admission Assessment, dated 07/31/15, revealed the resident was assessed to be alert, confused, and to be experiencing poor short and long-term memory. Further review of the Admission Assessment revealed the facility assessed the resident to have mild to moderate cognitive impairment and to require assistance with mobility.

Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 07/31/15, revealed the resident was referred to OT due to "new onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced balance, reduced ADL (Activities of Daily Living) participation, increased need for assistance from others, and decreased coordination placing the patient at risk for falls."

Review of the resident's Plan of Care with a revision date of 08/03/15, revealed the resident was at risk for falls related to confusion and dementia and required the use of an alarm when using a wheelchair.

Review of the History and Physical revealed Resident # 1 was admitted to the hospital on 08/04/15 after sustaining a fall from a wheelchair resulting in left orbital floor (facial bone) fracture, left sinus fractures, left maxilla (upper jaw bone) fracture, and a left humerus (bone in the upper arm) fracture.

Review of the "Resident Incident Follow-up," dated 08/04/15, revealed Resident #1 was discovered on 08/03/15 at 11:55 PM on the floor next to his/her bed by Certified Nurse Assistant (CNA) #3 and Licensed Practical Nurse (LPN) #3 after the resident's roommate notified facility staff.

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The staff members assisted the resident off the floor and then assisted the resident to the bedside commode for toileting. The resident was assessed at that time and found to have no injuries. CNA #3 assisted the resident back to bed; however, the resident stated he/she did not want to stay in bed. CNA #3 then assisted the resident to his/her wheelchair and took the resident to the nurses' station for close observation. The resident was witnessed to stand up from the wheelchair, grab the nurses' station, and fall to the floor on 08/04/15 at 12:20 AM.

Review of witness statements taken by the facility, dated 08/04/15, revealed CNA #3 stated the resident "kept trying to get up" so the CNA assisted the resident to a wheelchair and took the resident to the nurses' station. CNA #3 stated he went to locate a wheelchair alarm and while he was looking for the alarm, Resident #1 fell.

Further review of the statements revealed LPN #1 stated the resident was found to be standing unassisted two (2) times during the evening shift (3 PM to 11 PM) on 08/03/15. According to the statement, the resident had a working wheelchair alarm in place at the time. The LPN stated after the resident attempted to stand unassisted two (2) times, she placed the resident in the hallway for closer observation.

Interview with LPN #2 on 08/10/15 at 5:20 PM revealed she was involved in the admission process for Resident #1. The LPN stated Resident #1's family had indicated the resident had fallen at home in the past. Further interview revealed the LPN placed a wheelchair alarm on the resident upon admission as a preventive

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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measure for falls.

Interview with LPN #1 on 08/10/15 at 4:45 PM revealed she was responsible for Resident #1's care on the evening of 08/03/15. The LPN stated she was alerted by the resident's wheelchair alarm on two (2) occasions during the shift. The resident was found to be standing without assistance on both occasions. Further interview revealed after the second occurrence of the resident standing without assistance, staff placed the resident in the hallway for closer observation while the LPN completed medication pass. The LPN stated she verbalized to the oncoming nurse (LPN #3) that the resident was found standing unassisted and required a wheelchair alarm.

Interview with CNA #3 on 08/11/15 at 3:15 PM revealed Resident #1's roommate alerted him that the resident was on the floor on 08/03/15 at 11:55 PM. The CNA stated he found Resident #1 sitting on the floor beside the bed. He stated the resident stated he/she had "scooted" out of bed and needed to use the restroom. CNA #3 stated he and LPN #3 assisted the resident to the bedside commode and assessed the resident, finding no injuries. He stated LPN #3 was called from the room to check in a medication delivery. Further interview revealed CNA #3 stated he assisted the resident back to bed from the bedside commode. He stated the resident was sitting on the side of the bed and was fidgeting with his/her socks. CNA #3 reported he asked the resident if he/she wanted to get up and the resident agreed. The CNA assisted the resident to his/her wheelchair and took the resident to the nurses' station. CNA #3 stated the resident did not have a wheelchair alarm in place. Further interview revealed the CNA was instructed by

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	185173	A. BUILDING _____ B. WING _____	C 08/11/2015

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LPN #3 to get an alarm for Resident #1. He stated he left the resident at the nurses' station in sight of LPN #3 and went to locate an alarm. CNA #3 stated he was not made aware during shift-to-shift report that the resident required a wheelchair alarm and did not recall if the "Accunurse" (headset system that directs CNAs on resident care needs) directed the use of a wheelchair alarm for Resident #1.

Interview with LPN #3 on 08/10/15 at 5:55 PM, revealed after Resident #1 was discovered on the floor of his/her room on 08/04/15 at approximately 11:55 PM, she and CNA #3 assisted the resident to the bedside commode. LPN #3 stated Resident #1 was assessed and was found to have no injuries. The LPN stated she was called from the room to check in a delivery of medication at the nurses' station. The LPN stated the resident would not stay in bed so CNA #3 assisted the resident to the nurses' station in a wheelchair.

Further interview with LPN #3 revealed a wheelchair alarm was not in place at that time and she felt the resident needed an alarm in place on the wheelchair. LPN #3 stated she instructed CNA #3 to locate and place an alarm on the resident's wheelchair. The LPN stated she was checking in medications with the medication delivery person when she witnessed Resident #1 stand unassisted and fall forward to the floor. LPN #3 stated she was unaware the resident required a wheelchair alarm and had not reviewed Resident #1's care plan. She stated she asked the CNA to apply an alarm per nursing judgment. The LPN also stated she was not informed that Resident #1 was standing unassisted during the previous shift on 08/03/15.

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F 323	Continued From page 15 Interview with the medication delivery person on 08/11/15 at 1:19 PM revealed he was at the facility on 08/04/15 at the time of the resident's fall checking in medications with LPN #3. Further interview revealed the medication delivery person and LPN #3 were approximately six to eight feet from the resident and confirmed no alarm was sounding when the resident fell. Interview with the Director of Nursing (DON) on 08/11/15 at 4:50 PM, revealed Resident #1 should have had a wheelchair alarm in place prior to the fall on 08/04/15. The DON stated alarms could be implemented by nurses using their judgment and did not require a Physician's Order. The DON further stated that fall prevention interventions should be placed on the care plan. The DON stated that all care plan updates and interventions were reviewed during the morning administration meeting. The DON stated updates/changes that were identified in the morning meeting were placed in the "Accunurse" system. Interview with the Administrator on 08/11/15 at 5:45 PM revealed a wheelchair alarm should have been in place for Resident # 1 prior to the fall. The Administrator further stated that all incidents and accidents were discussed in the morning meetings, and any care plan updates and interventions were reviewed and updated in the "Accunurse" system.	F 323		